Healthcare Workforce Advisory Committee Meeting

MINUTES JANUARY 15, 2009 10:00 am – 1:00 pm VIRGINIA DEPARTMENT OF HEALTH, MEZZANINE CONFERENCE ROOM

MEETING CALLED BY	Virginia Department of Health, Office of Minority Health & Public Health Policy (Division of Primary Care & Rural Health)
FACILITATOR	Kathy Wibberly, Ph.D.
NOTE-TAKERS	Michelle Johnson and Aileen Harris
ATTENDEES	**Beverly Beck** (Dept. of Health Professions); **Linda Bohanon** (Virginia AHEC); **Stephen Bowman** (Joint Commission on Health Care); **Gary Crum** (Southwest Virginia Graduate Medical Education Consortium); **Millie Flynn** (VCU-SON); **Thomas Gaskins & Margaret King** (Virginia Community Healthcare Association); **Susan Motley** (Virginia Nurses Association); **Beth O'Connor** (Virginia Rural Health Association); **Ann Peton** (VCOM); **Sarah Jane Stewart** (Virginia Health Care Foundation); **Dr. Dixie Tooke-Rawlins** (Dean, VCOM); **Dr. Michelle Whitehurst-Cook** (Dean/Admissions, VCU-SOM); **Nathaniel Worley, Jr.** (EVMS – Community & Family Medicine); and staff in the Office of Minority Health & Public Health Policy.

Brainstorming & Strategic Planning Topics for Discussion

Meeting focused on four workforce-related challenges for group discussion and brainstorming:

1. Future of Recruitment and Retention in the Commonwealth;
2. Health Professions Pipeline Infrastructure;
3. Future of Incentive Programs and Match to State Loan Repayment Program; and
4. State Rural Health Plan – Workforce Council Recommendations.

CHALLENGE 1	**Future of Recruitment and Retention in the Commonwealth**
DISCUSSION	• **Challenge:** Recruitment and retention for Virginia's nonprofits (e.g., small hospitals, rural health clinics, and community health centers) is not coordinated and is under-resourced to meet the needs that exist. Smaller hospitals and clinics don't have a voice, and they typically don't have staffing to do recruitment and retention. In fact, many small hospitals report that they don't have time to fully complete the 3RNet application or to sell their communities. CAH's can charge recruitment functions to their cost report, but they can't hire someone full-time because their demand is low…thus, when they have a vacancy, they have difficulty. • Additionally, they don't have funds for marketing or to hire a headhunter. Many of these smaller facilities rely on OMHPHP to assist with recruitment efforts. This is done mostly through the use of 3RNet and PPOVA. For the purpose of this discussion, we are speaking of "recruitment and retention" in broad terms to include: filling positions, support in advertising position, helping families transition to job and communities, helping practitioners with practice management and other matters that may help retain them, and linking them with incentive programs offered by the State. • o The Office of Minority Health and Public Health Policy (OMHPHP) is involved in some recruitment activities, but it is not a function that is funded. OMHPHP utilizes 3RNet and PPOVA for recruitment and promotion, however there is only one FTE available to manage all of the Offices workforce efforts AND this FTE is currently also serving as the Acting Rural Health Manager; o The Virginia Community Healthcare Association (VaCHA) tries to support the recruitment needs of its 33 centers. They are presently overloaded

with 33 centers in 4 states and 30-45 vacancies on average, per month. Grant funds only provide recruitment support for community health centers. Vacancies are approximately 75% family practice and internal medicine, 15% mid-levels, 10% other (behavioral health, pharmacists, dentists, etc.);
    - The academic institutions and the AHECS also provide some support to recruitment efforts.
    - No one, at present, has the capacity to do the retention piece.

- **Question:** How do we do recruitment and retention for smaller non-profits (urban and rural)?
    - **Idea #1** – develop a non-profit recruitment and retention entity for those areas and small hospitals that are challenged with recruitment and retention. This includes:
        - 24 SHIP hospitals, which includes 7 critical access hospitals; rural health clinics; and other small community hospitals. This could also include the community health centers.
        - Question: Could this activity be contracted out? If so, to whom?
    - **Idea #2 -** Collaborate more with other entities.
        - "*Return to Roots Program"* (Carl Mitchell)—within VA Economic Bridge—online program that advertises job openings to people who grew up in the area and moved away…encouraging them to come home—they've had technical positions in medical field filled;
        - GMEC - has community descriptions on their website that might be useful in helping small entities promote their communities.
        - Consider utilizing academic departments in areas such as health administration, social work and other appropriate departments for internships, graduate work study to assist hospitals complete the form to post positions. Another possible project to complete is to develop a State Directory of all pipeline programs with descriptions. Need to develop the internship and go to the departments to recruit.
        - May not need to create another non-profit entity but consider a *"joint venture"* with other agencies with a similar mission. This may be easier to establish a "natural home" for recruitment and retention. Look for an entity where funds can be pooled together.
            - This would be an excellent fit for AHEC;
            - Big chains are a problem because they also recruit for other states; will also be challenging to get larger facilities - hospitals in competing chains to work together;
            - Is the Virginia Hospital Association willing to be involved? Though they haven't been interested in recruitment, they can be utilized to provide education (i.e. practice management, etc.);
            - The Medical Society of VA needs to be a player;
            - Consider the Chambers of Commerce and various business communities as they may be willing to assist; also the regional economic development groups may be able to help;
    - **Idea #3:** Have the CAH's pool resources and hire one person to work for all of them? Must be an entity to hire, provide administrative support—possibly Resource Center, GMEC to contract services proportional;
        - If they all kick in $3,000, they could pay a recruiter or a recruiter

	and a half to just focus on recruitment only; ▪ Recruiter needs to be in the area of need and not in Richmond. ▪ **Question:** Where would the recruiter be situated: • VDH? No. Too many barriers • AHEC? Might be a better fit; **Idea #4:** Look at recruitment and retention models in other states to examine how they are meeting these challenges. It was commented that many are fully funded and don't have this problem.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Draft a concept paper for a functioning recruitment and retention entity that may work in Virginia.	Dean Tooke-Rawlins (VCOM) & Millie Flynn (VCU-SON)	By the next meeting in June 2009.

CHALLENGE 2	**Health Professions Pipeline Infrastructure**
DISCUSSION	The health professions pipeline in Virginia is presently piecemeal and has many gaps. **Potential Solution:** House Bill 2142 • Intent was to establish enabling legislation to develop an infrastructure to coordinate the broad spectrum of workforce pipeline programs statewide to include: o provide the HWAC with a mechanisms for implementing recommendations o provide administration and unified vision, mission and direction for the AHEC program o provide administrative support for VDH incentive programs and recruitment and retention efforts o provide support for implementing State Rural Health Plan Workforce Council recommendations o Bring high level decision makers together to facilitate changes and improvements **Other Notes from pipeline discussion:** • Consider looking into model in South Boston- Southside Central on Nursing Excellence—where they work to fill pipeline gaps (partnership with six entities to educate own workforce and feed own pipeline); • Review again the workforce study completed by the Virginia Commonwealth University, School of Allied Health, Department of Health Administration – which indicated that most of the health practitioners working in VA, aren't trained in VA. **Question:** How do we make positions economically attractive? • Look at how we best get information out about the opportunities for professional students and residents and how do we best "groom" students and residents for rural and underserved areas. Most effective way to get them to serve—work in underserved area during residency or as a student. • Consider the utilization and recruitment of nurse practitioners to do some of the work – would be worth a community's effort to give nurses scholarships to work in a community – change in requirements—doctorate—will make that cost prohibitive.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Submit a request to the sponsor of the bill to take the bill under study – ask for a letter to be sent to VDH asking them to coordinate groups and move forward. A representative from the Joint Commission on Health Care (Stephen Bowman) has agreed to speak with Delegate	Representatives to work on this recommendation will be Stephen Bowman, Linda Bohanon, Thomas Gaskins and Rick Shinn.	ASAP

Nutter about this matter. ○ This gives the group a full year to work through all details of the authority; ○ Suggest having two levels of oversight within the Authority structure…smaller group to hire and fire executive director and can work together to develop policies….. 2nd level to act as in advisory capacity; ○ Group needs to determine appropriate title/name during study period as the proposed name may be confused with other existing entities.		

CHALLENGE 3	**Future of Incentive Programs and Match to State Loan Repayment Program**
DISCUSSION	The Virginia State Loan Repayment Program (Va-SLRP) is a federal grant awarded to States and requires a dollar-for-dollar match. Due to the State's budget cuts, the state-match is "frozen" for the next two fiscal years. OMHPHP is now considering pursuing community matches to continue to program. Va-SLRP is an attractive program as it is a tax-exempt program and eligibility is open to many more primary care providers, outside of physicians (NP, PA, general dentist, general psychiatrist). OMHPHP made the largest number of awards last fiscal year. A total of 18 Va-SLRP awards were made ($721,998 expended). Suggestions were solicited from the group: ▪ Comment – can the State utilize a fiscal depository with another agency so that future funds from collections can't be taken during future budget cuts? ▪ Comment – consider "tapping" various communities instead of foundations, which may only want practitioners in their area. ▪ Comment – can the Virginia schools come together to partner and provide loan repayment after residency? ▪ Comment – we need to better educate the foundations to bring them up-to-speed about a recruiting network; pipeline and incentives issues.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
ITEM (1): To survey all the foundations regarding what they may already offer, if anything, and to inquire about possible match;	Not designated	
ITEM (2): Members of HWAC will request a meeting of all the foundations to bring them together regarding funding challenges to recruit practitioners to rural and underserved areas.	Sarah Jane Stewart & Susan Motley	TBA

CHALLENGE 4	**State Rural Health Plan – Workforce Council Recommendations**
	2009 Rural Health Summit • At the 2009 Rural Health Summit, one focus will be addressing EMS policy issue—no delegated authority responsible for the continuity of EMS services in rural areas – this is a major gap. This will be an opportunity to bring stakeholders to

	the table. A round-table discussion will take place at the Summit, scheduled for ***Tuesday, March 10, 2009.*** HWAC members are encouraged to help get the word out to key stakeholders about the EMS Round Table. ▪ Most local governments don't fund; ▪ EMS is mostly, if not all, volunteer-based; ▪ Services within the first hour of emergent event is critical; ▪ Some hospitals have picked up the slack, but still can't fund EMS services; ▪ Education issues—training and continuing; ▪ Competition for trained people;
DISCUSSION	• Question: What have other states done to address the issue? Missouri has a good model to look at. **OTHER NOTES FROM WORKFORCE COUNCIL RECOMMENDATIONS:** • The State provided each council with funding ($5,500) to move forward with selected recommendations; ▪ Will be meeting within the next 4-5 months to figure it out • Need to work with medical schools to provide physicians what they need to be successful in rural settings; • Train-the-trainer program for physicians so that they can effectively work with residents (VRHRC); • Residency programs are becoming more strict with their requirements and residents, which sometimes prohibit their residents from attending meetings, etc. They can't easily come-and-go; • Dialogue needs to happen at all levels for rural care – OMHPHP shared that they have had conversations with VCU's Psychiatry department about a "rural tract" for mental health.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
ITEM (1): An HWAC representative has agreed to check with Nebraska who is working on this for their State as well.	Ann Peton	By next meeting in June 2009.
ITEM (2): OMHPHP is interested in collecting anecdotal EMS information and stories (both positive and negative) – with a blog or electronic town hall…put in local papers	No HWAC member designated	

TOPIC	**HWAC Business**
DISCUSSION	The organization and formalization of this group—Do we wish to appoint members or keep key stakeholders around the table by invitation? Group decided that there's probably not a need to deal with appointments, just keep organizations (per the Code) and other key stakeholders around the table. This can keep the continuity of members around the table. Question: Frequency of meetings. It is required to have an annual meeting, but is this enough? Comment: HWAC needs to move beyond what is done at the VDH but needs to include all workforce in the State.

Action items	Person responsible	Deadline
ITEM (1): Discuss at next meeting who the key stakeholders should be, outside of the Code? **ITEM (2):** It was decided by the group to meet at least three times a year. 1. Winter Annual HWAC Meeting to be held in Richmond (December/January) 2. Spring Mid-Year Meeting to be held by EVMS (June/July) ▪ Discussion will include all relevant stakeholders, budget and legislation passed and follow-up on action items. 3. Fall Strategic Planning Meeting to be held by VCOM (October/September) **ITEM (3):** The Virginia Statewide AHEC representative will take on the role with assisting OMHPHP to plan HWAC meetings and logistics.	All Linda Bohanon	By next meeting in June 2009.
Public Comments	**None provided**	